		AND HUMAN SERVICES  & MEDICAID SERVICES	uc	4	6 9184113	FORM	APPROVE		
STATEMENT OF DEFICIENCIES (X1) PROVI		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING 01 - MAIN BUILDING 01			OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED			
445244			B. WING			07/22/2013			
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE					
LIFE CA	RE CENTER OF CLE	VELAND			IO KEITH ST NW EVELAND, TN 37311				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	ID PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO		DBE COMPLETIC			
K 017 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In sprinklered buildings, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls properly extend above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to the corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.)  19.3.6.1, 19.3.6.2.1, 19.3.6.5		Ko	017	What corrective actions(s) will be accomplished for those residents for have been affected by the deficient practice; The unsealed penetrations revealed fire wall above the sprinkler piping to repaired by the Maintenance Direct How you will identify other resider having the potential to be affected same deficient practice and what corrective action will be taken; All other fire walls were inspected to Maintenance Director to ensure the no penetrations.  What measures will be put into play what systematic changes you will rensure that the deficient practice of the systematic changes you will rensure that the deficient practice of the systematic changes you will rensure that the deficient practice of the systematic changes you will rensure that the deficient practice of the systematic changes you will rensure that the deficient practice of the systematic changes you will rensure that the deficient practice of the systematic changes you will rensure that the deficient practice of the systematic changes you will rensure that the deficient practice of the systematic changes you will rensure that the deficient practice of the systematic changes you will rensure that the deficient practice of the systematic changes you will rensure that the deficient practice of the systematic changes you will rensure that the deficient practice of the systematic changes you will rensure that the systematic changes you will rensure	found to nt ed in the g were ctor. ents ed by the bere were			
	This STANDARD is	s not met as evidenced by:	1 and		recur; and The Maintenance Director will inspet that contractors have worked to en penetrations were left unsealed.	ect areas			
	revealed that the fo large unsealed pen- piping.	e: / 22, 2013 at 2:35 p.m. ur (4) hour fire wall has a etration above the sprinkler			How the corrective action(s) will be monitored to ensure the deficient will not recur; i.e., what quality assurance will be put into place. The Administrator will monitor this corrective action to ensure continuous compliance.	practice surance			
K 018 SS=D	acknowledged by the conference on July NFPA 101 LIFE SAI	FETY CODE STANDARD	ΚO	18					
LABORATOR)	PURECTORS OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	IATURE		TITLE		(X6) CATE		

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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Facility ID: TN0602

TITLE

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(X6) CATE

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 07/25/2013 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 01 - MAIN BUILDING 01 COMPLETED 445244 B. WING 07/22/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE LIFE CARE CENTER OF CLEVELAND 3530 KEITH ST NW CLEVELAND, TN 37311 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION DATE PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE **DEFICIENCY** K 018 Continued From page 1 K 018 What corrective actions(s) will be 08/09/13 Doors protecting corridor openings in other than accomplished for those residents found to required enclosures of vertical openings, exits, or have been affected by the deficient hazardous areas are substantial doors, such as practice: those constructed of 1% inch solid-bonded core The East Wing corridor time clock room, wood, or capable of resisting fire for at least 20 East Wing time boiler room, skilled wing minutes. Doors in sprinklered buildings are only corridor employee room, & skilled wing required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors boiler room doors will have the louvered are provided with a means suitable for keeping area covered with a solid plate. the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. How you will identify other residents 19.3.6.3 having the potential to be affected by the Roller latches are prohibited by CMS regulations same deficient practice and what in all health care facilities. corrective action will be taken; All other doors in the center have been checked by the Maintenance Director and were found to be in compliance. What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur: and This STANDARD is not met as evidenced by: All doors in the center will be checked on a Based on observation, the facility failed to have quarter basis by the Maintenance Director corridor doors resist the passage of smoke. to ensure we meet NFPA 101 Life Safety Code Standards. The findings include: How the corrective action(s) will be Observation on July 22, 2013 at 11:30 a.m. and monitored to ensure the deficient practice 11:50 a.m. revealed louvered doors in the will not recur; i.e., what quality assurance following locations: program will be put into place. East Wing corridor time clock room. The Administrator will monitor this 2. East Wing time boiler room. corrective action to ensure continued Skilled Wing corridor employee room. 4. Skilled Wing boiler room. compliance. These findings were verified by maintenance and

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DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 07/25/2013 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CHA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 01 - MAIN BUILDING 01 COMPLETED 445244 07/22/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3530 KEITH ST NW LIFE CARE CENTER OF CLEVELAND CLEVELAND, TN 37311 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) K 018 Continued From page 2 K 018 acknowledged by the administrator during the exit conference on July 22, 2013. K 027 NFPA 101 LIFE SAFETY CODE STANDARD K 027 What corrective actions(s) will be accomplished 09/06/13 SS=F for those residents found to have been affected Door openings in smoke barriers have at least a by the deficient practice: 20-minute fire protection rating or are at least Upon observation on the 3 hour fire door that 13/4-inch thick solid bonded wood core. Non-rated would not latch, hardware has been ordered to protective plates that do not exceed 48 inches replace existing hardware to be in compliance. from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. How you will identify other residents having the Doors are self-closing or automatic closing in potential to be affected by the same deficient accordance with 19.2.2.2.6. Swinging doors are practice and what corrective action will be not required to swing with egress and positive latching is not required. All facility corridor doors were inspected by the 19.3.7.5, 19.3.7.6. 19.3.7.7 Maintenance Director to insure proper closure. What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur; and This STANDARD is not met as evidenced by: The 3 hour fire door will be inspected at each Based on observation and testing, the facility fire drill by the Maintenance Director to ensure failed to have fire doors positively latch. proper latching and adjustments. The findings include: How the corrective action(s) will be monitored to ensure the deficient practice will not recur: Observation on July 22, 2013 at 2:30 p.m. i.e., what quality assurance program will be put revealed that the 3 hour fire doors would not into place. positively latch upon testing. The Administrator will monitor this corrective action to ensure continued compliance. This finding was confirmed by maintenance and

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72, 9.7.2.1

acknowledged by the administrator during the exit

conference on July 22, 2013.

K 061 NFPA 101 LIFE SAFETY CODE STANDARD

will sound when the valves are closed.

Required automatic sprinkler systems have

valves supervised so that at least a local alarm

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What corrective actions(s) will be accomplished

for those residents found to have been affected

that there is an indicating valve for an Automatic

Upon observation the facility did not identify

by the deficient practice;

Sprinkler System.

K 061

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08/08/13

SS=D

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 07/25/2013 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING 01 - MAIN BUILDING 01 445244 07/22/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE LIFE CARE CENTER OF CLEVELAND 3530 KEITH ST NW CLEVELAND, TN 37311 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES 1D PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION DATE PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) K 061 Continued From page 3 How you will identify other residents having the K 061 potential to be affected by the same deficient practice and what corrective action will be taken: We consulted the Cleveland Fire Department This STANDARD is not met as evidenced by: Fire Inspector in regards to the current Automatic sprinkler system set up. Based on observation, record review, and interview, the facility failed to provide a listed What measures will be put into place or what indicating valve for the automatic sprinkler system systematic changes you will make to ensure in an accessible location, so located as to control that the deficient practice does not recur; and all automatic sources of water supply. Upon review, the Cleveland Fire Department has generated a letter to the facility stating that all The findings include: automatic sprinkler system standards are in compliance. Observation, record review and interview with maintenance, administration, and sprinkler How the corrective action(s) will be monitored technician on July 22, 2013 at 1:00 p.m. revealed to ensure the deficient practice will not recur; that there is no indicating valve for the automatic i.e., what quality assurance program will be put  $^\circ$ sprinkler system for water shut off. The Administrator will monitor this corrective This finding was confirmed by maintenance and action to ensure continued compliance. acknowledged by the administrator during the exit conference on July 22, 2013. K 062 NFPA 101 LIFE SAFETY CODE STANDARD K 062 What corrective actions(s) will be accomplished 08/86/13 SS=F for those residents found to have been affected Required automatic sprinkler systems are by the deficient practice: continuously maintained in reliable operating Upon observation, the facility did not have condition and are inspected and tested documentation of the full flow trip test for the 19.7.6, 4.6.12, NFPA 13, NFPA 25, periodically. dry system. Further review identified no low 9.7.5 point drains for the dry system. Outside contractor will install low point drain and perform a full flow trip test at completion. This STANDARD is not met as evidenced by: Based on observation, record review, and interview, the facility failed to install and maintain the automatic sprinkler system.

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The findings include:

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DEPAR	IMENT OF HEALTH	AND HUMAN SERVICES			P		): 07/25/2013		
<u>CENTE</u>	RS FOR MEDICARE	& MEDICAID SERVICES			0		APPROVED		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			MB NO. 0938-0391 (X3) DATE SURVEY COMPLETED		
		445244	B. WING						
NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF CLEVELAND				STREET ADDRESS, CITY, STATE, ZIP CODE 3530 KEITH ST NW CLEVELAND, TN 37311					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BF	(X5) COMPLETION DATE		
K 062	Continued From page 4  Observation, record review, and interview with administration and the sprinkler technician on July 22, 2013 at 11:30 a.m. and 1:00 p.m. revealed the following:  1. No full flow trip test for the dry system.  2. No auxiliary/low point drains for the dry system sprinkler.  These findings were verified by maintenance and acknowledged by administrator during the exit conference on July 22, 2013.		K 062 How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; The Maintenance Director will monitor and maintain supporting documentation to ensure all required testing is completed as required to be in compliance.  What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur; and The Maintenance Director will monitor and maintain supporting documentation to ensure all required testing is completed as required to be in compliance.  How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place. The Administrator will monitor this corrective action to ensure continued compliance.			ient e i sure all o be what re and i sure all o be ored cur; se put			

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